Mercy Diagnostics
Ph. 877.514.5504
Fax 844-328-4894
www.mercydiagnostics.com

RESTRICTED TEST AKNOWLEDGMENT FORM

Please fill out completely and fax back to 844-328-4894

The following ordered testing may be considered experimental, genetic, or esoteric in nature and not covered under Mercy Diagnostics billing paradigm. If denied, the patient may be responsible for paying at a discounted self-pay rate.

Date: _____/_____/_____

Practice Name: _____

Patient Information
(Section Required)

Date of Service: _____/_____/_____ **Order Number:** _____

Ordering Provider: _____

Patient Name: _____ **DOB**: _____/_____/_____

Restricted Test(s) Ordered: _____

Discounted cost to patient if insurance does NOT cover: $_____

Patient notified and has accepted to pay additional cost? YES or NO (circle one)

Comments:

Provider and/or Patient Confirmation:
(Section Required)

Name of Person Completing Form: _____

Provider and/or Patient:_____ Date: _____/_____/_____

Testing will not be performed until signed acknowledgment is received